TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
South Texas Radiology

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-15-3707-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
July 13, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Patient provided Workers Comp information at the time of service. She was seen at Methodist Hospital Emergency Room Department for constant Lower Back Pain which was from a work related injury. Now our claim and request for reconsideration are being denied based on Lack of Authorization."

Amount in Dispute: $77.64

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Therefore, the documentation from South Texas Radiology Group does not meet the criteria of the above definition. No payment is due."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 5, 2015	72131	$77.64	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.2 defines emergency.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Precertification/authorization absent
   - 786 – Denied for lack of preauthorization or preauthorization denial in accordance with the network contract

- W3 – In accordance with TDI-DWC Rule 134.804 this bill has been identified as a request for reconsideration or appeal
- 193 – Original payment decision is being maintained
- P12 – Workers' compensation jurisdictional fee schedule adjustment
- 785 – Service rendered is integral to service requiring preauthorization. Preauthorization not sought/approval not obtained for that service
- 899 – Documentation and file review does not support an emergency in accordance with Rule 133.2

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the respondent liable for the services in dispute?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 899 – "Documentation and file review does not support an emergency in accordance with rule 133.2." 28 Texas Administrative Code §133.2 (5) states in pertinent part, Emergency--Either a medical or mental health emergency as follows:

   (A) a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in:

   (i) placing the patient's health or bodily functions in serious jeopardy, or

   (ii) serious dysfunction of any body organ or part;

   (B) a mental health emergency is a condition that could reasonably be expected to present danger to the person experiencing the mental health condition or another person.

   Documentation submitted does not meet the definition of emergency. Therefore no additional reimbursement can be recommended.

2. Pursuant to requirements of Rule 134.2 no additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		August 5, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.